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ORIGINAL ARTICLES.

LACUNAR TONSILITIS.

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Lacunar tonsilitis is an acute inflammation of the lacunæ or crypts of the tonsils. It is a self-limited disease and characterized by a whitish-yellow exudate, sometimes forming a membrane of variable extent. The erroneous term "follicular," which is usually applied to this condition, has been to a great extent discarded. The point of difference is that the follicles of the tonsils are only affected secondarily; the tonsilar crypts or lacunæ being most generally affected, and the chief seats of the disease.

The use of the two terms has led to much confusion. That "follicular tonsilitis" may be "croupous" in the sense of there being fibrin in the exudation, hardly justifies that distinction as opposed to "diphtheritic," since the occurrence of fibrin is merely indicative of the extent of the injury. Neither is the occurrence of the membrane of diphtheria itself distinctive, since numerous caustics may produce a membrane identical to that seen in diphtheria. Kopolik (*New York Medical Journal*, 1894) has described several "lacunar tonsilitis diphtheria" cases. In eighteen out of thirty-nine only staphylococci and streptococci were found.

Follicular or acute cryptic tonsilitis, which is the most interesting form, is not follicular at all, but a simple or desquamative infection, due to streptococci, staphylococci or pneumococci, and is also probably contagious.

One hundred varieties of micro-organisms have been described by Miller as existing in the normal mouth, and an interesting question arises as to why these should suddenly and under unknown conditions produce pathological changes and invade the general system.

Lacunar tonsilitis occurs after operative interference in the nasal cavities, especially when the galvano-cautery is used. It also occurs when cutting instruments or caustic applications are employed. We cannot but suppose, therefore, that a causal connection exists between the intra-nasal interference and the tonsilitis, for the latter occurs in individuals who have never suffered from it previously. It has been known to occur in one and the same person each time the cautery has been used in the nose. It occurs frequently during the first days after the intra-nasal interference, and involves either the palatine or pharyngeal tonsils, or both of them, at once. The explanation that has been offered is that something is carried by the lymph or blood circulation from the nose to the tonsils which sets up the inflammation in the latter. By this we are led to believe that the injury which damages the protective epithelial lining of the nasal cavities

throws open the doors to the exciters of inflammation and that through this door they obtain access to the tonsils from within by way of the lymphatics.

Tonsils are prominent portals of entrance for various micro-organisms. This is due to the physiological gaps of the covering epithelium, which are large enough to give easy passage to emigrating leucocytes and emigrating microbes.

Both tonsils are usually affected and the condition may extend to the faucial pillars, palate and pharynx. Fraenkel reports a case of its occurrence upon the lingual tonsil. Involvement of the cervical glands is not an uncommon accompanying symptom. The onset is characterized by the rapid rise of temperature, sense of uneasiness in the throat and difficulty in swallowing. Upon examination the tonsils appear red and swollen, with whitish elevated spots, which, upon closer inspection, are seen to be the secretion issuing from the orifices of the lacunæ. These may be seized and pulled away and usually appear in the form of threads, which retain an attachment in the lacunæ. The infection from one lacuna to the other may explain the appearance of a membranous formation over the tonsil. The secretion consists mainly of a large number of cells (chiefly leucocytes and epithelial cells); also, of micro-organisms, chiefly cocci, but no fibrin.

With the further progress of the disease the redness and swelling of the tonsils increase, but these phenomena, as well as the pain in the throat, usually keep within moderate bounds; while, on the other hand, the fever advances with rapidity, a temperature of 40 degrees C. or more being reached during the first evening of the illness. Next morning the fever remits but again rises in the evening, until during the night the crisis of the temperature declines to normal, with the occurrence of perspiration and urinary sediment. In some cases the fever may cease within twenty-four hours; in others it may continue for three or four days. In all cases, however, it gives the impression by the suddenness of its onset and by its termination in crisis of an effective fever, which is strengthened by the disproportion which exists between the local phenomena and the height of the fever, while it is further supported by the fact that in a fraction of all cases a swelling of the spleen is to be detected. When the infection occurs in individuals who suffer from hyperplasia of the tonsils, and they are frequently attacked by it, the performance of the necessary tonsilotomy during the acute stage of the disease is sometimes indicated on external grounds. Experience in such cases proves that tonsilomies performed during angina lucanaris do not differ in their course from the usual operation.

In considering the etiology we limit ourselves only to those cases which are unquestionably instances of lacunar tonsillitis. We exclude, therefore, from our etiological investigation all those cases in which pseudo membrane occurs, or in which the Loeffler bacillus is found. It is not desired to convey the impression that in simple lacunar tonsillitis the inflammation may become intense, that fibrin is secreted and that false membrane is formed. To make a clear distinction between lacunar tonsillitis and diphtheria, it is best in the etiological investigation to leave these forms out of consideration and confine ourselves to typical and perfectly pure cases. For the same reason we must exclude all cases in the secretion of which the Loeffler bacillus occurs.

The fact that it goes from the nose to the tonsils is a point of importance. The question arises as to whether the micro-organisms which cause lacunar tonsillitis are necessarily introduced into the body from without or whether they are

already in the tonsils, but must await an injury to the mucous membrane before they become pathogenic, a condition which is not only auto-infectious but capable of being transmitted from one subject to the other. An illustration of this is a case reported wherein a musician had acquired tonsillitis. At first there was no elevation of temperature, pulse small, rapid, and general condition bad. Second day, temperature 39 degrees C.; pulse, 108; meteorism and abdominal pains; enlargement of the spleen. Third day, it was apparent that the patient suffered from peritonitis. Fourth day, death occurred in spite of all remedies.

Post-mortem showed simple peritonitis without perforation; pulmonary edema and hypertrophy of the tonsils without membrane.

During the afternoon the physician cut himself and in spite of energetic disinfection was attacked the following day with lymphangitis, lymphadenitis and high fever. Having pain in the pharynx, an examination was made which disclosed lacunar tonsillitis. The wife and assistant also suffered from the same condition but finally recovered.

It is important to notice that many patients appear to be more emaciated and weaker after their recovery than the slight character of the local affection and the short duration of the fever would lead one to suspect.

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A CASE OF TRAUMATIC INJURY TO THE BRAIN INVOLVING THE TONGUE CENTER—OPERATION.

BY WILLARD BARTLETT, M. D., and SIDNEY I. SCHWAB, M. D.,
of St. Louis.

George G., a colored laborer of thirty-five, was brought to the Provident Hospital, July 13, 1903, in a semi-unconscious condition. He had been working, with a number of other men, on a railway trestle, when the structure collapsed and all were precipitated a distance of about fifteen feet to the ground. The patient, a massively built young fellow, had evidently fallen upon his head, to judge from the nature of his injuries, though we could get no trustworthy information upon the subject.

He remained partially unconscious and extremely restless for twenty-four hours, or until the afternoon of July 14th, when he was seen for the first time. It was then impossible to fully arouse him, though he did attempt incoherent replies to a few loud questions. There was no evidence of paralysis of bladder, rectum or extremities at this time or later. The right parietal region was the seat of two short, clean, linear scalp wounds, while this entire half of the head was so edematous that no reasonable conclusion could be drawn regarding the character of the bony vault, although the head had been shaven. The entire upper portion of the face was also so edematous that the eyes were completely closed, and to complete the abject picture, the saliva drooled continually from the angles of the mouth. At this time the respiration was labored and 22 to the minute, while the temperature was 99.4° in the axilla. But most interesting of all, the pulse, which Dr. Davis assured us had been 72 one day earlier, was now 60.

During the night the patient continued very restless, muttering, and tossing his arms above his head, while the right side of the face twitched constantly. By the time we saw him, at ten o'clock next morning, it was almost impossible to arouse him at all from his unconscious state, and his pulse, which had decreased to 56 earlier in the day, was now only 42.

This case presented from the point of view of diagnosis and localization some very interesting problems. Their solution depended upon the utilization of data derived from a careful physical examination. The nature of the process and the exact part of the brain where this process was acting had to be determined before the question of surgical interference could be considered. The latter of the two questions is by far the more important to be answered. It is vastly more essential in traumatic brain cases to determine where the process is than what it is. That we had to deal with some lesion in the brain which produced a slowly developing increase in intracranial pressure was immediately apparent when the results of the two examinations made twenty-four hours apart were known. The increasing stupor and the decline in pulse-rate seemed to substantiate this fact with great precision. A fall of the pulse-rate from 64 to 42 in twenty-four hours, with no other apparent cause, left nothing else to be considered.

These facts then were sufficient to determine that not only had we to deal with a process causing an increase in intracerebral pressure, but, in addition, with some process which was causing a constantly increasing pressure. In other words, there was an increase in volume of the determining cause of the pressure symptoms.

A slowly organizing hemorrhage is the most common cause for this condition. So with considerable certainty it was thought that we had to do with an escape of blood organizing into a clot which was slowly increasing in volume by the addition of freshly formed coagula. The next point to decide upon was the localization of this clot. The possibility or the advisability of an operation would depend upon this to a great measure. At the first examination there was absolutely no localizing sign at all; and although an operation seemed advisable, it was determined to wait twenty-four hours in the hope that the general pressure symptoms would be augmented by some definite localizing sign that would indicate where the process was.

At that time it was agreed that in the absence of any such symptom the skull would be opened in such a way that the two linear scalp wounds referred to above would be included in the area of operation. The uncertainty of such a procedure was fully considered, and the fact that damage to a brain may bear little or no relation to the seat of the scalp wound was well known to us. At the next examination, however, the first evidence of a localizing sign was apparent. The tongue on protrusion deviated markedly to the left, showing that the left side of the tongue was paralyzed. It was only with the greatest difficulty that the examination could be carried out, on account of the stupor. When the mouth was opened, the tongue could be seen lying turned to the left side. It is to be noted that the tongue was frequently thrust out mechanically, as though there was some form of irritation at the seat of the cortical center involved. The tongue center lies in the lower third of the motor area, a little anterior to the anterior central convolution and above the sylvian fissure. It is in close proximity to the island of Reiland, is connected with the lower face muscles and the

motor speech fibers. Immediate operation was now decided upon, it being the intention to cut down upon the center involved, remove the clot and stop the bleeding. This was carried out one hour later, after the region of the tongue center of the injured side had been indicated upon the scalp.

Operation.—A sharp-pointed knife was thrust through the scalp at the point just mentioned, and the skull scratched as deeply as possible, then a large horse-shoe-shaped flap of scalp was removed, as soon as it was determined through the primary incision that the skull was the seat of a comminuted fracture, and that an osteoplastic flap could not be made. The scratch on the skull, above alluded to, was now plainly seen, and around it as a center the De Vilbis rongeur quickly bit out an area some two inches in diameter. Exactly beneath this opening there lay a disk-shaped clot almost as large as a man's palm and some half an inch in thickness. With the removal of this mass we were gratified to observe the pulse go up immediately to 85. The cavity was loosely stuffed out with iodoform gauze, to stop a moderate oozing that persisted, the wound sutured, except at the point of exit for the gauze, and the patient put to bed in fair shape.

It must be distinctly understood, in passing, that the area of bone splintering was beneath the scalp wounds, and well behind the area originally determined for the tongue center; so it can be readily seen that we might have removed the bone fragments and overlooked the cause of all the trouble, had we simply followed external indications, instead of allowing ourselves to be guided by the one focal symptom in the case and cutting down upon a predetermined center.

The further progress of the case is extremely simple: on the fourth day the gauze was withdrawn and the remainder of the wound sutured, first intention being obtained throughout.

The patient was no longer restless, while he regained consciousness in a few days, though the ability to articulate distinctly was slow in returning. The tongue was completely paralyzed for about one week, and there was also following the operation a paresis of the right arm.

On August 6, 1903, twenty-two days after the operation, the man was discharged from the hospital entirely well and with a pulse of 70.

A study of this case in its various phases points in no uncertain way to the value of three considerations, viz.:

1. That the entire scalp must be shaven before an examination of it can be considered complete.
2. That no absolutely reliable examination of the skull is possible until the scalp has been removed.
3. That a localizing symptom is of far greater value than any external evidence of injury, as an indication of the proper point for operative attack.

THE RELATIONSHIP BETWEEN CERTAIN CATARRHS OF THE SKIN
AND CERTAIN CATARRHS OF THE MUCOUS MEMBRANE
OF THE EYE, EAR, NOSE AND THROAT.

BY MARTIN F. ENGMAN, M. D., of St. Louis, Missouri.

The principal point to which I wish to refer is the auto-infectious nature of certain diseases of the mucous membranes and the skin; affections which when co-existent seem to be by this means in direct relationship to each other, although in each location a distinct and separate term is given to them. The first in importance and the most prevalent are the various catarrhal affections of these tissues, which may, by the difference in the virulence of the process, be seen as various clinical types of disease; of a purulent, sero-purulent or dry catarrhal nature. Thus in both the mucous membranes and the skin we may have, co-existent, inflammatory processes varying in their clinical symptoms according to the local reaction of the tissue involved. Upon the skin auto-infection of these catarrhs is a usual occurrence, especially in children.

The careful observation of these various co-existent conditions unites so intimately, by a chain of clinical facts, the catarrhs of the mucous membranes of the eye, nose, throat, ear and the skin, that their discussion may, for the sake of brevity in this sense, be of a general and inclusive character.

To illustrate what is meant by the above remarks we will cite a typical case. Usually a child or young adult appears for advice, presenting the following symptoms: Upon the skin of the face, and sometimes upon the arms, neck and scalp, are crusted, weeping areas of inflamed skin, ranging in size from a patch as large as a silver dime to that of the palm of the hand, with here and there over the rest of the face small crusted points, which are the initial lesions from which the larger patches form. The eyes are secreting a purulent or sero-purulent discharge, while the lids are swollen and the lashes are clumped by crusts of dried exudate. The upper lip is edematous and covered by a dermatitis of a similar nature to that above mentioned, caused by a sero-purulent discharge which flows over it from the nostrils; or, the latter may be almost closed by yellow or greenish crusts, the dried discharge. To complete the picture, one or both ears in many cases are also discharging with a dermatitis about the external canal or the concha. By close questioning of this patient or its relative it will often be found that the various catarrhal conditions had extended successively from one locality or region to another, either beginning upon the skin from, possibly, an accidental abrasion or trauma of some character; or by an infectious discharge from the nose after a "cold;" or from the eye after a conjunctivitis; or after a "sore throat," idiopathic or symptomatic, the chin, lower lip or some region about the mouth, being the initial infection incited by the infectious saliva.

The case we have cited is, of course, a severe one, but not an infrequent picture in our experience.

We know how frequent it is to find a so-called eczema about a discharging ear. Also about the lids after a conjunctivitis. Many of these cases have I seen in the Polyclinic in conjunction with the gentlemen in the various departments.

In my private practice and in Dr. Hardaway's clinic at the Polyclinic, I have seen many cases where close questioning elicited the fact that the rhinitis or conjunctivitis had appeared *after* the skin infection, having, no doubt, been conveyed to the mucosa of the nose by contaminated fingers, especially in children who delight in picking the nose; or to the conjunctiva by rubbing with the fingers or infected cloths.

By the older writers cases of the character cited are termed *scrofulous*; probably because there often ensues enlargement of the adjacent lymphatic glands from absorption of the local intoxication or infection. But why *scrofulous*?

Of course, it is probably necessary for the proper infection of these various localities to have a certain degree of lowered resistance, but when we see phenomena which are plainly of an auto-infectious nature, why go further for an explanation and grope about in the ancestral history of the patient for a cause?

Unna calls a certain type of this catarrh, "*tuberculous eczema*," for the same indefinite reason as the English and French *scrofula*, he having no evidence on which to found this name.

Last September I discussed a subject which included the group of infections to which we have referred, under the title of "*An Infectious Form of an Eczematoid Dermatitis*." In that discussion it was affirmed that there was an infectious dermatitis caused by a variety of staphylococcus, which might gain access to the skin by an abrasion or from auto-infection from a catarrhal mucous membrane. A year has passed and during this interval I have pursued my study of this subject with the result that I am now even more thoroughly convinced of the truth of that statement.

It is impossible to go into the details in this short paper as the subject is a very broad and vast one, striking at the vital "*eczema question*," over which there has been so much contention in the last few years.

The clinical fact that these catarrhs of the various regions are infectious, is the principal point of my discussion. Dr. Hardaway and Dr. Wolfner some years ago carried on, jointly, a series of clinical observations to determine the relationship of seborrheic eczema of the scalp and certain granular and catarrhal conditions of the eyelids. From personal conversations with these gentlemen upon their studies, I learned that they both consider that there is probably an infectious relationship between the two localities in these conditions. Dr. Hardaway speaks of this in his text-book on diseases of the skin; but, strange to say, after a very thorough search of the literature, I have found no other author who speaks of the apparent infectious relationship between catarrhal processes of the skin and mucous membranes. All of them attribute these catarrhs, when co-existent, to unknown constitutional causes.

Of course, we must admit a proper soil, in the present state of knowledge upon infections, but, to me, the prime factor in the production of all the symptoms is a specific micro-organism. The day of saddling so many diseases of the skin of unknown origin upon *scrofula*, rheumatism, gout, climate, diet, etc., is fast waning. We are striving for a more exact pathology. On account of the rich flora of the skin it is a giant task to study any disease of the skin bacteriologically; but when we find an organism in pure culture as a constant associate in a certain disease, one is prone to study its significance, especially so if we produce by its artificial inoculation lesions similar to those from which it was obtained. The last few years I have been studying a variety of staphylococcus

found in these catarrhs. I find this coccus so constantly and have had so many confirmatory experiments with it, that I am led to believe it to be an etiological factor in these afflictions, very probably the cause under certain conditions.

To those interested in the various clinical types I have mentioned, it seems to me this subject is of great importance, and certainly worthy of painstaking clinical study, for it is of great practical as well as scientific value to determine the exact relationship between these frequently co-existent catarrhs.

It is very probable the fundamental principle of all catarrhs is the same whether it be upon a mucous membrane or the skin. The slight histologic difference can be explained by the special physiologic and anatomic nature of the tissues.

Besides the catarrhs there are several other diseases of the skin which bear a close relationship with diseases of the nose, and are of special interest.

Stricker (*Dermatologischer Centralbl.*, December, 1898) states that erysipelas may serve as a type of a class of affections which actually originate in the nose and thence are distributed by lymph-paths to the face, the primary lesion being intranasal. This, he says, is true of glanders; for wherever the organism is introduced into the system, the nose is invariably the first organ to be affected.

In a great many cases of leprosy there is an ulcerous destruction of the mucous membrane over the septum, and as this lesion is the only approach to a constant phenomenon of leprosy, Stricker goes so far as to regard it analogous to the syphilitic primary lesion. This leprosy lesion in the nose always contains the lepra bacilli in great numbers and forms a focus for secondary infections upon the face through the lymph channels. Stricker traced the lymphatics from the nasal septum over the face by means of injected specimens and finds that the distribution harmonizes with the peculiar localization of certain facial eruptions, such as acne rosacea, lupus erythematosus, leprosy; all of which are often seen grouped as follows: forehead, nose, chin, ears. Deposits of disease in these sections Stricker claims are favored by the tendency to arterial fluxion and venous stasis in the same localities.

G. D. Murray (*Med. Rec.*, 1899) makes a plea for the careful search for some irritation in the nose in the treatment of all skin lesions of the face, where the origin is uncertain. He founded his plea upon eleven cases of eruptions on the face of an erythematous and acne-like character relieved by the correction of nasal stenosis.

The observations of these writers is interesting and no doubt of great value. In leprosy, erysipelas, syphilis and lupus erythematosus I can confirm their opinions, but if they mean by acne, acne vulgaris or comedo-acne, I cannot agree with them. Acne vulgaris is, probably, a local bacillary infection of the follicles and glands. However, there is a disease characterized by a small, superficial pustule upon the front of the face, especially about the cheeks and nose, which I have frequently seen in those with some affection of the nasal mucosa, and have believed there was some direct relationship between the two conditions.

We undoubtedly have in connection with the nasal mucosa and skin two methods or avenues of auto-infection: (1) by means of the lymphatic channels; (2) by the direct inoculation of the infectious secretions.

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EDITORIAL COMMENT.

THE VALUE OF THE OMENTUM IN LAPAROTOMY.

How often we have occasion to remark that it is only by the grace of nature's extreme friendship for the surgeon that he is enabled to accomplish any results at all. This is surely true as regards the matter of infection; for example, what surgeon supposes for an instant that he really can create a wound and prevent one single germ from entering the same until it has been closed again? If the matter of aseptic wound healing were not aided by the resistive powers of the human organism as opposed to the virility of the bacterial organism, then there would be no such thing as the "first intention" on which we pride ourselves, often without giving due credit to our partner in the affair—indulgent mother nature.

In a recent article entitled "The Omentum as a Protecting Organism," Renzi and Boeri (*Berliner Klinische Wochenschrift*, No. 34, 1903) have very completely brought out several of the advantages which we derive in the course of a laparotomy from the nearby presence of this potent helper. Its ability to form adhesions and through the new vessels thus furnished to supply the spleen with sufficient blood, is noted after ligation of either the main artery or vein entering the hylus of that organ. Suppose that all the vessels entering the hylus of the spleen be ligated, then the organ becomes necrotic in a short time as a matter of course; but the value of the omentum in this connection becomes apparent when in a few days it is seen that the dying organ has been completely surrounded, or, as it were, encapsulated by this apron with all its vessels greatly distended. Then if the observation be carried on for a sufficiently long period

it will be seen that the remains of the spleen have been completely absorbed. But suppose the vessels at the hylus to be ligated and the omentum to be removed at the same time, then there is no resorption and the animals die in a few days, though the time of death can be postponed if the one or the other operation be delayed for a certain length of time.

The same thing may be said of the relation of the omentum and the kidney, in spite of the fact that the latter organ does not lie wholly within the peritoneal sack, in the ordinary acceptance of the term (knowing that from the strict anatomical reality) that both lie wholly outside this membranous covering.

It is further worthy of remark in this connection that foreign bodies which find their way into the abdomen are often completely wrapped around by the omentum and remain for months or years undisturbed in the new surroundings.

We all know that the omentum is usually treated as a foreign body or, indeed, as an enemy to the patient and ruthlessly ligated and large portions removed, with regard for the fact that no other organ (if it can be so designated) is known to have such protecting qualities; this, too, where there can be shown to exist no good and sufficient reason for taking it away. Then, too, adhesions to its extremity must form wherever it be divided, and this is in itself often a matter of consequence.

We are only too well aware of the way in which this apron includes such threatening enemies as the inflamed appendix and thus holds peritoneal infection in check until resolution be accomplished or until an operation be performed. But most interesting of all is the knowledge that a large defect in the wall of a hollow viscus can be closed with a patch of omentum, and that the columnar epithelium will grow by continuity from adjacent mucous surfaces until the inner aspect of the new patch is covered.

A BEVERAGE OF VIRTUE.

If the writer in a recent number of the *Journal of Tropical Medicine* is to be credited, an infusion from the dried leaves of *plex paraguarensis* is what the world long has sought—a perfect and harmless stimulant. Paraguay tea, unlike all stimulants, unlocketh no secrets, bids hope to come and be realized, makes the coward a hero and teaches accomplishment. This unnamed correspondent of the *Journal of Tropical Medicine* claims that the sustaining and stimulating effects of an infusion of *plex paraguarensis* is very remarkable; that the lazy and indifferent South American, under its influence, becomes an unflagging, industrious Yankee of endurance. Woodcutters commence their labors at day-break and work with increasing and unwearied energy for six or seven hours, and so long as they get their “mate,” vigor and accomplishment assume continuous sway. The writer, after an extended experience, avers that it is invigorating and sustaining, with different powers from those of tea or coffee or cocoa. When taken as a stimulant for night work, study, late watching or nursing, it conveys an energy and vim which make work and duty a glowing and real pleasure.

Unlike wine, it does not heighten love into indifference, but into duty; nor does it cause love to grow into jealousy and jealousy into madness. Instead of converting the good-natured man into an idiot and the choleric into an assassin, it makes him a dutiful, working divinity. It robs bitterness of resentment, saps insupportable vanity and never displays the soul's deformity. No devil bides in this beverage. It is a decoction made up of virtue, duty and morality.

It is best taken as a very hot infusion through a metal tube, but it can also be taken in the same manner as tea and coffee, with milk and sugar. After a short experience most people prefer to drink it native without any admixture. While it is very bitter, like all bitter things, experience soon makes it an agreeable and even palatable drink. Upon analysis there seems to be nothing in the drug which explains its virtues. The percentage of caffeine and the amount of volatile oil is very much less than that contained in tea or coffee.

After three years' experience this correspondent has been unable to discover any evil effects from the use of this admirable stimulant, it being averred that even when the consumption of the decoction becomes an actual mania, no special evil results.

NERVOUS "PROSPERITY."

When some sprightly writer among the laity delves in nosological lore, the results are very apt to be unique and scintillant.

Thus a writer in a recent issue of a lay journal informs us that "nervous prosperity" is a disease. He did not state whether lustihooded poverty can be classified in the same manner. Continuing, he very knowingly says: "Women, having duties which, if not fewer, are less compulsory than those of men, are peculiarly subject to this complaint. Their physical strength is less, their nervous system more complicated. The American climate in the northern states is enticing. A person can drink more coffee or alcohol without feeling stimulated in London and most foreign capitals than he can in New York or Chicago. Many who cannot sleep in the United States are less troubled with insomnia abroad."

It is plain that the writer, having thus successfully started in defining nervous prosperity, has no timidity in airing his views. While he leaves us in doubt as to whether nervous prosperity has an hysterical or a neurasthenic element, he yet remains firm in his conviction as to the force of modern surroundings.

In these days of strenuousness all things have become strenuous. Prosperity in the last few years has become more hugely prosperous than it has in all past æons of time. Prosperity when reckoned in millions becomes intensely self-appealing and productive of self-introspection, and too much self-introspection is a throttler of weak minds and a strenuous pathologizer. In fact, too much prosperity is much more pathologizing, all things considered, than ordinary poverty. Our writer views the modern tendency of haste as disease-producing, because it begets both bodily and mental tension. Cable cars with gongs and crowds, railways overhead, underground and otherwise, packed streets, automobiles, telephones, telegrams, messenger boys, all beget tension. Accomplishment being almost incredibly broadened, many persons acquire a passion for late hours and create that new anomaly, the somnophobiac, the person afraid of sleep.

The somnophobiac of old is the lunatic, but the word sleep has lost its soothing mellifluence. No thought comes to him of delicious, peaceful oblivion. Unlike normal man he will not willingly and delightfully shut up his senses nor will he hoodwink his soul or shut the trap-door of his brain to the outer noisy world. To be neither dead nor alive, yet both and neither, his soul is not on earth, mayhaps, still less in heaven.

We may doubt the propriety of laymen becoming medical authorities without cause or foundation, yet such thoughts as these have much in them and suggest ideas of more than picturesque wording.

MEDICAL AND SURGICAL PROGRESS.

INTERNAL MEDICINE.

IN CHARGE OF

JESSE S. MYER, M. D.

The Dwarf Tapeworm (*Hymenolepis Nana*), a Newly Recognized and Probably Rather Common American Parasite.—STILES (*New York Medical Journal*, November 7, 1903), in his examinations of 3,500 patients, found the dwarf tapeworm sixteen times, the *tænia saginata* twice, and not a single case of *tænia soleum*. The writer is of the impression that this parasite is rather prevalent, but has been overlooked because of its small dimensions. It is slightly less than two inches in length. It has four suckers and a crown of hooks.

About one hundred cases have been recorded in man, the first case in this country being reported by Spooner in 1873.

The regular channels through which man becomes infected have not been established. It seems probable that rodents, especially rats and mice, are the regular hosts for this worm. The eggs of the parasite may be spread to the food through the droppings of these rodents. The worm inhabits the ileum of man, and may be found in varying numbers.

The writer reviews in detail the history of this parasite, the symptoms produced by their presence, diagnosis, treatment, etc.

The Agglutinating Qualities of the Bile and the Serum from Cases of Icterus.—KONIGSTEIN (*Wiener Klinische Wochenschrift*, No. 35, 1903) carried on experiments with reference to bile in agglutination tests. In twenty-one cases in which human bile was used he did not meet with a single positive reaction. The same results were met with when the bile from rabbits, cows, etc., was used. He concludes, from his observations and experiments, that the serum of icteric cases acts just as that of a healthy individual does when applied to typhoid cultures.

The Gruber-Widal Reaction in Icterus.—JOACHIN (*Wiener Klinische Wochenschrift*, No. 35, 1903) found in the observation of icteric cases that the agglutination test was negative to the bacterium coli and the bacillus dysenteriae; that the test was positive in its application to vibrio cholera and the bacillus pyocyaneus, even in high dilutions.

In the case of the typhoid bacillus the reactions were somewhat different.

The serum from cases of cholangitis produced agglutination promptly, even in high dilutions, while the serum from cases due to carcinoma gave tardy reactions only in low dilutions.

A Review of Some Recent Investigations Relating to the Pancreas.—HART (*Medical News*, No. 14, Vol. 83) reviews in detail the recent literature relating to the physiology and diseases of the pancreas. To Pawlow is due the credit for the impetus recently given to research along these lines. Opie and Bayliss and Starling are prominently mentioned. The conclusions of the latter are especially interesting.

The secretion of the pancreatic juice is normally evoked by the entrance of acid chyme into the duodenum, and it is proportional to the amount of acid en-

tering (Pawlow). This secretion does not depend on a nervous reflex, and occurs when all nervous connections of the intestine are destroyed.

Contact of the acid with the epithelial cells of the duodenum causes in them the production of a body (secretin) which is absorbed from the cells by the blood current, and is carried to the pancreas, where it acts as a specific stimulus to the pancreatic cells, exciting a secretion of pancreatic juice proportional to the amount of secretin present. This substance, secretin, is produced probably by a process of hydrolysis from a precursor present in the cells which is insoluble in water and alkalis, and is not destroyed by boiling alcohol. Secretin is not a ferment.

The pancreatic juice obtained by secretin injection has no action on proteids until "enterokinase" is added; the action on fats is increased by the addition of succus entericus. It is, in fact normal pancreatic juice.

Secretin rapidly disappears from the tissues, but cannot be detected in any of the secretions. It is not possible to obtain a body resembling secretin from any tissues of the body other than the mucous membrane of the duodenum and jejunum.

Secretin solutions, free from bile salts, cause some increase in the secretion of bile. They have no action on other glands. Acid extracts of the mucous membrane normally contain a body which causes a fall of blood pressure. This body is not secretin, and the latter may be prepared free from the depressor substance by acting on desquamated epithelial cells with acid. There is some evidence of a specific localized action of the vasodilator substances, which may be extracted from various tissues.

Carcinoma of the Pancreas and Its Diagnosis.—BURT (*Postgraduate*, October 3, 1903).—Primary malignant disease of the pancreas is not often encountered. There were but twenty cases of this nature among six thousand autopsies at Guy's Hospital, and twenty-two in something over eighteen thousand at the Vienna General Hospital. The author reports such a case, in which the diagnosis was based upon a tumor in the epigastric dilatation of the gall bladder, due to pressure on the common duct, deep jaundice, peculiar greasiness of the skin and dejecta and the subjective symptoms.

Cholecyst-duodenostomy was performed. A tumor about the size of a hen's egg was found in the head of the pancreas.

A Case of Combined Pyloric Cancer and Phlegmonous Gastritis.—McCASKEY (*Medical Record*, No. 15, Vol. 64).—Suppuration as a surface process in gastric cancer is probably not very rare, but its occurrence with the formation of a distinct and well-defined abscess cavity in the stomach is of interest. The writer reports such a case, in which there was clinical evidence of cancer, the gastric contents containing no hydrochloric acid, considerable amounts of lactic acid and much pus.

The blood examination showed 24,000 leucocytes. The autopsy revealed cancer of the pylorus, in the body of which there was an abscess cavity an inch and a half in diameter.

Two New Methods of Determining the Digestive Activity of Gastric Juice.—BETTMAN and SCHROEDER (*Medical Record*, October 31, 1903) describe two new methods for determining the digestive activity of gastric juice, which they term (1) the method with albumen foam, and (2) the centrifugal method.

The first method is described as follows:

A small quantity of the gastric juice is diluted with three times its volume of a 0.2 per cent. solution of HCl; 1 c.c. of the diluted gastric juice is placed in a

homeopathic vial, and to it is added 2 c.c. of a 1 per cent. solution of egg albumen containing 0.2 per cent. free HCl. The vial is thoroughly agitated (fifty violent shakes usually suffice) until a column of foam about 2 c.m. high is formed. The vial is now placed in the incubator at 37° C.-40° C., or in water kept at that temperature, and the time required to clear the surface of foam is noted. In the one-fourth dilution of a normal case the foam will disappear in twenty minutes. If this time is divided by two it will represent the time required by the original undiluted gastric juice, and from this time the actual pepsin strength of the gastric juice can be calculated.

The second process is briefly described as follows: The gastric juice to be tested is diluted with three times its volume of a 0.2 per cent. solution of HCl. This diluted juice and the standard albumen solution are placed in the incubator about fifteen minutes in order to be warmed to the body temperature. In each of two test tubes are placed 10 c.c. of the standard acidified albumen solution. To one tube 5 c.c. of the diluted gastric juice is added; to the other (the control tube) 5 c.c. of a 0.2 per cent. solution of HCl. These tubes are then placed in the incubator at 37° to 40° C. for exactly seventy minutes. At the end of that time they are removed, and 10 c.c. are taken from each tube and placed in the centrifugal tubes graduated to .02 c.c. To each tube is added 5 c.c. of a 10 per cent. solution of trichloroacetic acid, and after inverting the tubes several times they are placed in a high-speed centrifugal machine and centrifugalized two hours. At the end of this time the tubes are removed and the volume of sediment measured. The sediment in the control tube will be an index of the original albumen strength of the standard solution. The sediment in the second tube will be less, if digestion has taken place, the difference representing the proportion of albumen which has been transformed into peptone.

Rheumatoid Arthritis.—BISHOP (*Journal of Advanced Therapeutics*, No. 9, Vol. XXI) considers rheumatoid arthritis a progressive disease of the nervous system, due to faulty metabolism, affecting primarily the centers and nerves that exert a trophic influence upon the tissues of the body, and is characterized in the early stages by a torpid condition of the entire muscular system, a general feeling of fatigue, with a sense of soreness, pain and stiffness of the extremities, especially of the fingers, wrist, knees and ankles. This is followed by febrile attacks, each leaving in its wake some deformity.

The writer points out the necessity of the earliest possible diagnosis, with a view to applying the proper treatment promptly. His treatment is based upon the belief that impaired nutrition is primarily the cause of trophic changes, first, in the nerve center; second, in the nerves, and, third, in the muscles and joints.

Cardiaptosis and its Relationship to Hepaptosis.—EINHORN (*Berliner Klinische Wochenschrift*, October 12, 1903) describes a series of fifteen cases of cardiaptosis, tabulating them with reference to the exact position of the heart, of the liver and the kidneys, and the chief symptoms.

Emaciation, enteroptosis and neurasthenia play an important role in the etiology. The displacement of the heart occurs much more frequently in men than in women, which is attributable to the mode of dress. Palpitation, dizziness and difficulty of lying on the left side are the chief subjective symptoms.

In more than one-half the cases of cardiaptosis there was also a general enteroptosis, and in all the cases a greater or less degree of hepaptosis. This is readily explained by the fact that a ptosis of the heart necessitates a lower position of the diaphragm. All cases of hepaptosis are not accompanied, however, by a cardiaptosis.

SURGERY.

IN CHARGE OF

WILLARD BARTLETT, M. D.

Experimental Study of the Question of the Elimination of Bacteria from the Body.—NOETZEL (*Wiener Klinische Wochenschrift*, No. 37, 1903).—The question which the author presents for solution is essentially this: Does the kidney excrete bacteria in a physiological manner, or is the presence of many organisms in the urine merely a sign of disease in that gland? The number of organisms which leave the body through other glands can be neglected for all practical purposes, so small is it. At the same time, if we wish to establish a physiological principle, it must be shown that the germs leave the body very soon after they have been introduced. To get at a solution of the matter, the author took guinea-pigs and introduced aspirating needles into the bladder of each, after which he made intravenous injections of pure cultures. It was impossible to attain positive results, although some of the experiments were continued as long as two hours, thus showing that the kidney does not normally act in the manner indicated. When the kidneys of these animals were examined bacteriologically after death, many colonies were found, thus showing that the organs were the seat of disease.

Splenectomy in Splenomegalia with Cirrhosis Hepatis (Clinical Type—Banti's Disease).—QUENU and DUVAL (*Revue de Chirurgie*, No. 10, 1903).—In 1899 the authors had done the operation for the symptom picture to which Banti called attention in 1894, but unknown up to that time. There exists a singular parallel relation between the spleen and liver in these cases, though no one can explain just what the relation is. Still it must be admitted that the removal of the one (spleen) causes a cessation of the process in the other. The general impression, a vague one at best, seems to be that the whole affair depends upon some sort of an auto-intoxication from the digestive tract.

Four years after the operation this first case referred to above is still in good condition, which says much for the method of treatment. Death is usually caused by the anemia or by intestinal hemorrhages, and there is on record no case of spontaneous recovery. Of the author's four cases three recovered while one died from a uterine sepsis shortly after. The good results were immediate in all cases after the operation.

Concerning Rhinophyma.—V. BRUNS (*Beiträge zur Klinische Chirurgie*, Band xxxix, Heft 1).—This rare but interesting condition, known variously as elephantiasis, hypertrophy, or acne rosacea of the nose, is not in reality confined to alcoholics, as was formerly supposed. The author has been called to operate eleven times for the condition though it is so rare, hence the present report is of peculiar worth. In but two of his cases was there any history of alcoholism. The photographs which accompany the article are certainly as perfectly illustrative of the fine points involved, as one could wish to see. The deformity consisted in some cases of lobes so overgrown that they hung down over the mouth as far as the chin. In one case the patient had to push one lobe out of the way in order to enable him to eat. The inner structure of these tumors was always that of an adeno-cysto-fibroma, showing nowhere any of the characteristics which might lead one to think of a clinical malignancy. The only treatment consists of excision; here the tendency to healing per prima is always all that could be desired. Most of the eleven cases referred to were dismissed within a week.

The Surgical Treatment of Traumatic Hemorrhage of the Spleen.—SENN (*Journal of the American Medical Association*, November 21, 1903).—Senn proposes a new method of combating this form of bleeding, based upon the reasoning that we see it coming more often from the parenchymatous veins rather than from a main vessel at the hylus; further, that there is no muscular tissue in the organ to aid us and usually no firm capsule to the organ. Tampon of the wound, or removal of the organ, have given the best results up to date, but even these can be improved upon by crushing the wound edges with a long forceps and then sewing the crushed edges together. A number of experiments along this line gave uniformly good results, as far as the easy and prompt stopping of hemorrhage was concerned. This procedure is therefore to be regarded as more conservative than splenectomy, and hence given the choice over the latter so long as the texture of the organ is not so changed by disease as to render this form of hemostasis impossible. The other methods in vogue at the present time are fully considered together with their indications.

Experiences in Operating for Incarcerated Hernias.—WEYPRECHT (*Archiv fuer Klinische Chirurgie*, Band lxxi, Heft 1).—This article represents ten years' work at Urban, where they had the astonishing number of four hundred and two of these cases. Of these, three hundred and twenty-seven were operated upon, and of the total number, 14.4 per cent. died. In small hernias which had been incarcerated forty-eight hours, especially if there was swelling of the tissues, no manual attempt at reposition was made before the operation. There were seventy-two gangrenous cases, and of these 46.6 per cent. came to a fatal issue. The serous contents of the sac were examined bacteriologically in many instances, but it cannot be shown that the mortality was any higher in the cases where germs were found than in the others. Interesting but excusable mistakes in diagnosis were made: for instance, an inflammatory process in an empty sac led to the diagnosis of incarceration and operation; while in another patient a large lipoma was mistaken for incarcerated omentum. In only one of this large series of cases was the colon the sole viscus in the sac. It is the custom at Urban to cut down upon the constriction rather than divide it from within outward; thus infection is prevented to some extent.

There is but one method of determining whether or not an incarcerated gut will live after liberation, and that is by seeing contractions of it. The application of drops of water of a temperature between forty-five and fifty degrees Celsius, is the safest method which the author has been able to arrive at, and will arouse peristalsis if it can be done in any way. An important point urged by the author is the application of a suture which will fold in the line of the constriction, if there be any reason to suspect the possibility of gangrene at this point. It is wrong to fix a loop of intestine which is suspicious outside the abdomen, since this is the best way to further prejudice its nutrition; if immediate resection of such a loop be not immediately done, it is far better to replace it in the abdomen and then pack down to it; this prevents a general peritonitis in any event and at the same time gives the gut its best chance to recover vitality. A radical operation is to be done in all cases where it is possible and thus for all time dispose of a case at one sitting.

The danger of such an operation must be regarded as slight so long as the gut is intact and there are no serious complications. The establishment of an artificial anus has given very bad results in all hands and is to be thought of in these cases only when no severer proceedings can be contemplated on account of the patient's condition, or when a purulent peritonitis is present.

The Diagnosis of a Primary Gangrenous Appendicitis.—REYNIER (*Bulletins et Memoires de la Societe de Chirurgie de Paris*, Tome xxix, No. 31).—A patient whose history the author relates in detail had a severe chill at the outset of his

attack, then high fever succeeded by a fall of temperature in what he calls the septic fashion. The curve is regarded by him as characteristic for this form of the disease, in which he writes of the local and general symptoms as being out of all proportion to each other. In the case mentioned the temperature went up the second afternoon, in spite of the regulation treatment, so the author operated and found a partially gangrenous organ as the cause of the trouble, the recovery being uninterrupted from this time.

To recapitulate, the author's diagnosis of gangrenous appendicitis is founded upon the great oscillations in the temperature curve, together with a disproportion between the local and general symptoms.

The Use of Rubber and Lisle Gloves at the Same Time.—GOEPEL (*Zentralblatt fuer Chirurgie*, No. 42, 1903).—The rubber gloves are easily torn and the lisle gloves allow the germs to pass through them; both of which disadvantages can be overcome by merely wearing a pair of the cloth gloves over the others. The various advantages to be derived from the combination are summed up as follows and tabulated by the author:

1. The operator is protected from infection.
2. The operator can use the hand with much greater freedom and not fear infecting the patient.
3. During an operation the gloves can be changed and soiled hands be rendered at once aseptic.
4. Gloves render it easier to tie knots tight because the thread does not cut in; further, the lisle glove allows one to grasp instruments particularly firm.
5. Where it is necessary to have great fineness of feel, the outer glove can be quickly removed.
6. Where several small operations have to be done much time is spared from washing the hands; this can be omitted altogether if the gloves are not to be torn, which is unlikely by this method.
7. Eczema, etc., do not trouble the surgeon who wears gloves, since he is spared much of the necessity of scrubbing which he would otherwise have to undergo.

THERAPEUTICS.

IN CHARGE OF

ALBERT E. TAUSSIG, M. D.

A Case of Splenomedullary Leukæmia Successfully Treated by the Use of the Roentgen Ray.—NICHOLAS SENN (*Medical Record*, August 22, 1903).—In the *New York Medical Journal* for April 25, 1903, Senn reported two cases of pseudo-leukæmia that recovered under the x-ray treatment, and have continued in excellent health since. Not long after this favorable result a typical case of splenomedullary leukæmia entered his surgical clinic with the object of having the enormously enlarged spleen removed.

The patient was a foreign-born Jewess, twenty-nine years of age. Both family history and previous history were without direct bearing on the case. A year ago she began to experience a sharp pain at varying intervals in the left hypochondrium, attended by a sense of weight and fullness in the same region. This was soon followed by a dull, aching pain in the lower end of the sternum and the epiphyseal extremities of the large, long bones and by nearly constant occipital headache. On examination a point of exquisite tenderness was found at the junction of the gladiolus and ensiform cartilage of the sternum. The abdomen was greatly enlarged, a huge spleen extending two inches to the right of

the navel and below nearly to the pubes being easily made out. The liver, too, was palpable below the costal margin. The temperature varied from normal in the morning to 100° in the evening. The blood examination showed erythrocytes, 3,500,000; leucocytes, 64,800; hæmoglobin, 56 per cent.; many eosinophiles, myelocytes and pronounced poikilocytosis. Bland's pills and Fowler's solution were tried without benefit. As a last resort the x-rays were tried. The spleen, the lower end of the sternum and the epiphyseal extremities of the long bones were exposed to the action of the rays daily for from ten to twenty minutes. During the course of the treatment the use of the x-ray had to be suspended for a day or two on several occasions, owing to high temperature and other symptoms of intoxication. The spleen gradually grew smaller and the blood approached the normal. The first decided changes observed in the blood were the gradual disappearance of the myelocytes and the return of the red corpuscles to their normal shape. Four months after the beginning of the treatment the patient returned to her home "in excellent health;" the last blood examination revealed no abnormalities in the structure and relative number of red corpuscles and leucocytes. The writer believes that there can no longer be any doubt in reference to the microbic origin of leukæmia nor of the antimicrobial action of the Roentgen ray. The transillumination of the affected areas in this case unquestionably was the main curative factor and its action can so be best explained.

On the Hypodermatic Use of Adrenalin Chloride in the Treatment of Asthmatic Attacks.—J. BULLOWA and D. KAPLAN (*Medical News*, October 24, 1903).—At the Montefiore Home the writers had occasion to treat a large number of cases of bronchial asthma. The repeated failures of antispasmodics to cut short the attack led to the trial of adrenalin chloride, hypodermically, as a general vaso-constrictor, in accordance with the angio-neurotic theory of the etiology of the disease. Three cases are reported at some length, in all of which the usual treatment was without avail, but which were promptly cut short by injections of adrenalin. The attacks recurred as frequently under this treatment as before, but each attack being promptly aborted, the evil sequelæ following prolonged attacks, such as emphysema, would seem to be prevented. With fresh preparations of the drug, 3 to 6 minims of the 1 in 1000 solution, hypodermically, cut short the asthmatic seizure, usually without disagreeable sequelæ. It is worth while mentioning the fact that solutions of adrenalin chloride deteriorate from exposure to light and air and that the dose must be increased accordingly.

The immediate vaso-constriction necessary to cut short an attack can only be obtained by the hypodermatic method of administration. Much larger doses by the mouth do not cause this effect; sprays into the throat are also inefficient. Adrenalin chloride used externally produces only a local constriction of the blood vessels; for this very reason it is poorly absorbed from the mucous membranes and in order to affect the circulation in the lungs it must be introduced under the skin. Its hypodermic administration is not painful. Sometimes there is a blanching of the tissues about the site of injection; this may be obviated by injecting it more deeply.

Intractable Typhoid Hemorrhage Successfully Treated With Adrenalin.—B. GRASER (*Muench. Med. Wochenschr.*, July 28, 1903).—In a case of typhoid hemorrhage in which the bleeding steadily continued in spite of all efforts to check it, the desired result was promptly obtained after the administration of adrenalin. Thirty drops of the commercial solution were given every three hours. There were no ill after-effects.

Trigemin.—OVERLACH (*Berl. Klin. Wochenschr.*, No. 35, 1903).—This new analgesic is derived from pyramidon, by the action upon the latter of butylchloro-

ralhydrate. It seems to exert a specific sedative action upon the cranial nerves, but has no depressant effect upon the heart, so that it may safely be given in organic heart disease. It was found to be useful in all forms of headache and migraine, and especially in occipital and facial neuralgia and even in toothache. The dose is from 0.5 to 1.2 grams (8 to 18 grains) once or twice daily.

Local Hyperidrosis.—(*The Monthly Cyclopædia of Practical Medicine*, September, 1903; *N. Y. Med. Jour.*, August 8, 1903).—Where hyperidrosis is general, the cause—tuberculosis, arthritism, anemia, fever—will, of course, be treated. Agaricin, atropin, ergotin and sodium tellurate are not of much use except in tuberculosis; they are contraindicated in pyrexia. For hyperidrosis of the hands, feet or axillæ, local baths with vinegar, an infusion of walnut leaves and alum, one-fourth per cent. solution of potassium permanganate, or a mixture of a tablespoonful of commercial formol in a quart of water, all are curative. Subsequently the affected parts should be rubbed with the following lotion diluted with one or two parts of water:

R	Betanaphtol.....	5 parts
	Glycerin.....	10 parts
	Alcohol.....	100 parts
M.	For a lotion. To be diluted. (Brocq.)	

Or this may be substituted:

R	Thymol.....	1 gram (15 grains)
	Tannin.....	5 grams (75 grains)
	Camphorated brandy.....	200 grams (6 2-3 ounces)
M.	Lotion.	

Subsequently the feet should be carefully dried and powdered with talcum, starch or bismuth subnitrate, or with the following, the official foot powder of the French army:

R	Salicylic acid.....	3 grams (45 grains)
	Starch.....	10 grams (150 grains)
	Powdered tale.....	.87 grams (3 ounces)
M.	Foot powder.	

The following may be preferred:

R	Salicylic acid.....	3 grams (45 grains)
	Powdered alum,	
	Betanaphtol.....	of each 5 grams (75 grains)
	Sodium borate,	
	Powdered starch.....	of each 10 grams (150 grains)
	Powdered tale.....	.67 grams (2 1-4 ounces)
M.	Foot powder.	

A novel prescription is this:

R	Coal-tar.....	5 parts
	Plaster of Paris.....	100 parts
M.	Dusting powder.	

Another excellent and simple formula is:

R	Bismuth subnitrate.....	15 grams (4 drachms)
	Sodium salicylate.....	5 grams (75 grains)
M.	For external use.	

These powders should also be dusted into the socks and shoes. Every week or so the following should be rubbed in between the toes:

R	Red lead oxide.....	1 gram (15 grains)
	Liquid lead subacetate.....	29 grams (7 drachms)
M.	Lotion.	

Any local hyperidrosis will yield rapidly to a combination of the foregoing.

PATHOLOGY AND BACTERIOLOGY.

IN CHARGE OF

CARL FISCH, M. D.

Constitution of the Diphtheria-Toxin.—THORVALD MADSEN (*Centralbl. fuer Bacteriol. Orig.*, vol. 34, No. 7).—As is well known, Ehrlich found certain incongruities in the experiments on neutralization of diphtheria-toxin with antitoxin which did not directly agree with the principle of binding in constant proportions established by him. By an enormous amount of the most ingenious work he finally established a theory of the toxin-constitution that assumed the presence of various constituents in one and the same toxin-solution with different degrees of toxicity and affinity to the antitoxin. His toxin-spectrum seemed to explain the whole process of neutralization in a perfect way. His observations were at first confirmed by Madsen on the same toxin and on tetanolysin, but very soon a closer study of the binding process, made by the same author, showed that the chemical affinity to the antitoxin was not great, at least for tetanolysin, and that their combination could only be explained by the laws for dissociable substances. Gruber, Dreyer and others reported similar experiences, which made it very likely that the same relations would obtain for all of the immunity bodies. Ehrlich lately published an extensive article in which he admits the possibility of the truth of these assertions for certain substances, but denies that they could obtain for the diphtheria-toxin, which he continues to consider as a substance of very strong affinity for the antitoxin and combining with it in constant proportions. Madsen, in the above quoted paper, has now proven in a conclusive way that for diphtheria-toxin the curve of union between toxin and antitoxin follows the laws of the curves of all dissociable substances, and that according to these laws an absolute neutralization in such solutions cannot be obtained. There is no contradiction possible to this classic investigation, and the constant proportion principle will have to fall. This new aspect will bring about great changes in the whole conception of the immunity relations in a way that will lead us to a clearer understanding of their nature. It goes without saying that Ehrlich's work will continue to remain the foundation of all further work, in spite of the changes made necessary by these new investigations.

Value of the Agglutination for the Diagnosis of Typhoid Fever.—R. STERN (*Berl. Klin. Wochenschr.*, No. 30-31, 1903).—The positive result of the Widal reaction does not correspond to the same limit of agglutination effects in the methods of different observers. For the clinical valuation the differences in the agglutinability of the single cultures, sometimes, too, the presence in the serum of substances of antiagglutinable character can give rise to difficulties. Today we cannot consider the increase of the reaction to a dilution higher than 1:50 as a certain indication of an existing or passed infection with typhoid bacilli. Numerous investigations have lately shown that in the serum of an individual infected by a certain bacillus, agglutinins appear not only for this bacillus, but also for related forms. It is true that the serum usually agglutinates the bacillus, causing the infection more intensely than the related microbes, but exceptions do occur, and especially in cases where the agglutinative power of the serum is not very high. It must, therefore, be concluded that the serum diagnosis cannot altogether replace the demonstration of the infectious microbe itself. Furthermore, it is necessary to establish the clinical diagnosis by an approximately quantitative determination of the agglutinative power.

Embryoid Tumors of the Ovaries and Testicles and the Occurrence of Chorion Epithelioma in Them.—H. STEINERT (*Virch. Arch.*, vol. 174, No. 2).—Aside from the addition of a new case of chorion epitheliomatous structures, found in an embryoid tumor of the testicle, to the small number so far published, Steinert's paper is exceedingly valuable on account of the clear and logical discussion of the subject of embryoid tumors. Although their origin from embryonal tissue was long since recognized, and although there were always found in them structures formed by the three germinal layers, the absence of tissues referable to the embryonal egg-envelopes had never been seen. In spite of this the idea took hold that the origin of the tumors must date back to the earliest stages of fetal development, and consist either in a segregation of blastomeric cells or in the inclusion within the fetus of a fecundated polar body. Wilms was inclined to give the latter assumption the preference, not considering that we know that blastomeres, if detached from the dividing egg, may not only grow, but sometimes produce, in a way, the complete type of the organism under discussion. The fetus in fetu idea has claimed its followers for a long time and still does; this idea was necessary to assuming the formation from a polar body. Steinert calls attention to the fact that the presence of chorioma in tumors not directly embryoid points to a period of origin as early almost as the first few cell divisions themselves; to a stage where we know that the single cells can, under certain circumstances, give rise to the formation of all of the tissues of the three layers. The presence of these tissues is incontrovertible evidence of the correctness of the theory. Whether polar body or blastomere cannot be decided, but there is no reason to attribute the absence or presence of the products of certain layers in such tumors to the one or the other point. We know of embryoids consisting, for instance, of a single tooth lodged in the ovary, and a doubt about their nature as homologous to the more complex forms cannot be entertained. With the finding of products of egg-envelopes in embryoids the origin of the tumors is established; it is due to Schlagenhauffer that this assumption has become a truth.

In the same issue of the *Archiv Otto Busse* reports two cases of chorion epithelioma after pregnancy, in which the new formation had arisen in places away from the placental site. An interesting detail of his investigation was that in both cases the uterine mucosa showed the evidence of the reaction of pregnancy.

Burial of the Dead in Its Relation to the Public Hygiene.—D. MATTHES (*Zeitschr. of Hyg. und Infect. Krankh.*, vol. 44, Heft. 3).—That the alleged hygienic nuisance caused by the burial of the dead in its extent and importance is generally overestimated is an opinion held by all not prejudiced by a false sentiment. The propaganda for cremation, of course, does not openly appeal to this sentiment, but justifies its claims by assuming as a truth that hygienic calamities have been brought about by the burying grounds and are liable to be brought on at any time. Many epidemics of typhoid, cholera and other infectious diseases have been attributed to the proximity of these places and to the contamination of the water supply from them. Although it has long since been conclusively demonstrated that pathogenic germs disappear from the graves in a short time and cannot be found either in the grave itself or in the soil or in the water draining from it, the contamination of this water has constantly remained a source of suspicion. Matthes has for fourteen years kept a constant watch on the chemical constitution of the water from numerous wells situated on the grounds of the Ohlsdorf burying ground near Hamburg. The place occupies an area of 186 hectares and in it are over 260,000 dead bodies. The wells are supplied mainly from the drainage of the grounds. The observations were begun at a time when large tracts were not used for the purpose in question and control was kept during the gradual accumulation of graves on them. The general findings

were that the water differed in no way in its chemical quality from the water of surrounding localities, and especially that the amount of organic material in it was by no means higher. Nor was any change observed in the water of those areas that in the beginning of the investigation were unoccupied and only gradually filled with graves. Matthes' work is very conscientious and gives us at last a clear idea of the futility of all the apprehensions entertained concerning the danger of the home of the dead to the house of the living.

GYNECOLOGY AND OBSTETRICS.

IN CHARGE OF

HUGO EHRENFEST, M. D.

Internal Diseases as Contraindications Against Marriage from an Obstetric Point of View.—O. O. FELLNER (*Centralbl. f. Gyn.*, No. 43, 1903).—Fellner bases the conclusions of this most elaborate essay upon observations made in many thousands of cases in the famous Vienna clinic of Professor Schauta. Seventy different diseases are considered in this connection. For the sake of convenience the author divides the material into two categories, and asks the two questions: (1) When should the physician advise against marriage? (2) When should the physician warn against a new impregnation in the case of a married woman who has developed a certain disease?

It may be said right here that in a general way the author considers marriage contraindicated in all diseases which show a mortality of 10 per cent. or more.

Tuberculosis of the lungs belongs to the first category, but only the more severe type of this disease, because the average mortality is not above 9 per cent. Tuberculosis of the larynx, however, is considered an absolute contraindication. In all cases of mitral insufficiency marriage should be forbidden, and whenever there are any disturbances in the compensation; also in myocarditis. Matrimony must be prohibited in all cases of chronic nephritis and malignant growths; in benign growths operation before marriage would seem advisable.

In the group of diseases which may develop in a married woman, and contraindicate a new impregnation, are: Chorea, if the previous attack was a severe one; insanity, because especially all those forms which first appear during pregnancy show a distinct tendency to recur; epilepsy, only in its most severe form. The following diseases may form a contraindication if they have shown a tendency of becoming worse after a previous pregnancy: Pulmonary tuberculosis, heart failure, if there was a distinct disturbance in the compensation; Basedow's disease. Eclampsia does not belong in this group, because it does not have any tendency for recurrence.

It is, however, impossible to lay down any hard and fast rules; in many cases the decision will be dependent upon a careful consideration of particular obstetrical and medical features of the case.

A physician called upon to give his opinion in such an instance should ever keep before his eyes the three points: Prohibition of marriage may under certain conditions be a very cruel measure; very dangerous symptoms can eventually be averted by an artificial interruption of pregnancy; the responsibility which a physician takes upon himself by permitting marriage in doubtful instances is very great, indeed.

The Efficacy of So-Called Oxytoxics.—O. BACHMANN (Inaugur. Dissertation; rev. *Centralbl. f. Gyn.*, No. 41, 1903).—The author records the results of a series of experiments made in the Maternity of Breslau concerning the use of ergot and quinine in cases of uterine inertia. In one hundred and fifty-five cases quinin sulph. was administered in seven-grain doses, two doses within ten minutes; if result not satisfactory, one or two more capsules were given. The result was satisfactory in ninety-one instances, unsatisfactory in sixty-four. In twenty-six cases ergot was administered by means of hypodermic or intramuscular injection (four to five grains *pro dosi*). Result: Satisfactory in nineteen, negative in seven cases. The diagnosis *inertia uteri* was made (1) when the uterine contractions were distinctly weak; (2) when within several hours a visible progress of labor could not be noticed.

Distinctly different from this form of inertia are the cases in which a patient, after a long, tedious labor, with good uterine contractions, becomes completely exhausted. In these instances a subcutaneous injection of morphine (gr. 1-6 to 1-3) will give good results.

A Suggestion Concerning a New Treatment of Acute Sepsis.—J. WERNITZ (*Samml. Klin. Vortr.*, N. F., No. 352; rev. *Centralbl. f. Chir.*, No. 39, 1903).—The author bases his suggestion upon very satisfactory results obtained in several cases of puerperal septic infection and acute peritonitis, due to purulent salpingitis. The essential point in his treatment is the injection into the rectum of large quantities of fluid at a time when the general septic symptoms are prevalent and the symptoms of the local infection still somewhat obscure. The secretion of urine and diaphoresis are effectively stimulated, and in this way the elimination of the toxic substances circulating in the blood expedited. The advantage of this procedure as compared with subcutaneous or intravenous transfusion of salt solution lies in the fact that the resorption is left to the normal action of the rectal mucosa. The resorption takes place gradually, and a dangerous sudden overburdening of the heart, as sometimes observed after hypodermoklysis, becomes impossible.

These injections are made in the following way: A long rectal tube is introduced as high as possible. It is connected with a large irrigator filled with a warm 1 per cent. salt solution. The fluid is injected under a very low pressure. As soon as tenesmus appears the irrigator is lowered and a regurgitation of the injected water into the irrigator permitted. When the tenesmus disappears, water is again injected by raising the irrigator. This maneuver of raising and lowering the irrigator is continued, the soiled salt solution being constantly gradually replaced by fresh until feces and gases are thoroughly removed. And now the resorption begins. The rectum is kept filled with salt solution under low pressure, and if the procedure is kept up for about one hour from 500 to 1,000 c.c. will be resorbed. The effects of resorption are manifested in decrease of thirst, free perspiration, increased secretion of urine and lowering of the temperature. Return of the unfavorable symptoms, especially rise of temperature, give the indication for a repetition of the procedure, which has to be continued for at least one hour at the time, or until the described change in the symptoms is manifest.

As stated above, the author has used this method in general peritonitis and puerperal sepsis, and has obtained surprisingly good results. He believes, however, that these applications may prove useful also in the treatment of scarlet fever, typhoid fever, plague, etc., eventually tetanus; that is, especially in all those infections in which the general toxic symptoms are most pronounced. He suggests the use of such copious and systematic rectal injections as a prophylactic measure following extensive operations within the abdominal cavity.

PEDIATRICS.

IN CHARGE OF

ALFRED FRIEDLANDER, M. D.

The Relation of the Bacillus of Shiga to the Summer Diarrheas of Children.—

In the discussion of this subject at the last meeting of the American Pediatric Association, Flexner (*Archives of Pediatrics*, November, 1903) emphasized the following points: The bacillus of Shiga has come to be recognized as the cause of a definite group of cases of dysentery in adults. Under Flexner's direction fifty-two cases of infantile summer diarrhea were studied bacteriologically at the Wilson Sanitarium. In forty-five of these fifty-two cases the Shiga bacillus was isolated from the blood, and the blood serum of the children who showed the bacillus in the stools agglutinated pure cultures of the bacillus. The cases in which the organism appeared were cases in which both blood and mucus appeared in the stools. While there is no special difficulty in obtaining growths of the bacillus, once isolated, it is difficult to isolate the bacillus in the feces because of its similarity to the typhoid and colon groups. It is probable that the so-called "Shiga bacillus" in reality is a group organism with at least two distinct types.

In the discussion Park stated that the agglutination test with the Shiga bacillus is not always easily carried out, especially if the child has had previous attacks of diarrhea. He believes that the Shiga bacillus is not the direct etiological factor in the majority of cases, and that it is most apt to be found only in the cases showing both blood and mucus in the stools.

Koplik insisted upon the recognition of several types of summer diarrhea: (1) The pure dyspeptic; (2) the form caused by the bacteria in the milk itself—*e. g.*, bacillus of butyric acid; and (3) the infectious cases. Various germs may be the exciting factor here; staphylococcus infections have long been recognized. It is in this class of infectious diarrheas that the Shiga bacillus cases must be placed. It is impossible to say, at the present time, how large this Shiga group is, but Koplik believes that it is a limited one. The possibility of mixed infection must also be borne in mind.

Holt reported that Wollstein had studied the stools of one hundred and twelve cases of all kinds of intestinal disturbance. The Shiga bacillus was found thirty-seven times. All of these cases showed signs of colitis; most of them were acute; in no case where both blood and mucus were present was the bacillus absent, and characteristic blood reactions were obtained in all these cases. The bacilli persisted in the stools as late as six weeks after the attack.

Flexner's antidyenteric serum was tried in eight cases, only three of which showed resulting improvement. Autopsies in fifteen cases of Shiga colitis showed the entire absence of any characteristic anatomical changes.

Knox, who had charge of the Wilson Sanitarium, reported that of the cases in which the bacillus was found, at least ten presented the acute symptoms of dyspeptic diarrhea. A large number of the forty-two positive cases were sub-acute or chronic. The stools contained blood, not always in large amount, however. Knox confirmed Holt's observation in the absence of characteristic *post-mortem* lesions.

Booker referred to his early work in the diarrheas of infancy; stated that he had isolated between thirty and forty varieties of bacteria from the stools, and believed that no single species could be considered the exciting factor for all kinds of diarrhea. He believed that mucus or blood alone in the stools is not of such great moment; it is when mucus is clouded by leucocytes or blood is mixed with pus that these become of special importance.

With reference to the serum treatment, he believes that it can only avail in the early stages, before serious anatomical changes have occurred and before other organisms are brought into participation.

Flexner stated that he was convinced that whatever the Shiga bacillus does it does early; that there is nearly always a mixed infection later. He admitted that the use of the serum at the present time is merely experimental. For hopeful therapeutical effect it should certainly be given early.

Treatment of Infantile Diarrhea by Solutions of Gelatine.—WEILL, LUMIERE and PEHU (*Rev. Mens. des Mal. de l'Enf.*, October, 1903) report most excellent results from the use of gelatine in the diarrheas of infants. Chemically pure gelatine is taken and dissolved in ten times its weight of boiled water. The solution is then sterilized in an autoclave at 120° C. for a half hour. The solution is then tubed, putting 10 c. c. (representing one gramme of gelatine) in each tube.

The contents of one tube are then added to each bottle of milk given to the infant. In this way eight grammes of gelatine may be given a day, although they have used twelve or even fourteen grammes. The good effects of the treatment are seen very soon. The number of stools diminishes, they become more solid and lose their green color and offensive odor. The general symptoms improve rapidly—often after four or five tubes.

The medication finds its clearest indication in cases of dyspeptic diarrhea without organic lesion. In true cholera infantum good effects were not obtained.

The gelatine appears to have a direct effect upon the coagulation of the milk, and upon the intestinal secretions. The fermentative and putrefactive processes are stopped, perhaps by a purely physical process, as some experiments outside the body would seem to indicate.

In the author's opinion the addition of sterilized pure gelatine to milk offers a better method of treatment of infantile diarrhea than the usual drugs employed, such as bismuth, bismuthose tannigen, tannalbin, etc.

Concerning the Etiology of Pertussis.—REYHER (*Jahrbuch fuer Kinderheilk.*, October, 1903) reviews the literature and reports the results of his investigations concerning the specific etiologic factor of whooping-cough. He is able to confirm the claim of Czaplewski (made in 1897) that the specific germ is a small, non-motile, short rod, with egg-shaped rounded ends, which, morphologically as well as tinctorially, somewhat resembles the influenza bacillus. Distinct differences in cultural growth, as well as in staining properties, serve to differentiate it from this germ, however.

The carefully prepared and distinctly technical article, embodying as it does the result of an extended series of observations, does not lend itself to abstract, and should be consulted in the original by those interested. An extensive bibliography is appended.

NEUROLOGY.

IN CHARGE OF

SIDNEY I. SCHWAB, M. D.

The Condition of the Axis Cylinder in Multiple Sclerosis.—BARTELS (*Deutsche Zeit. fuer Nervenheilkunde*, Band 24, No. 56, 1903).—The role of the axis cylinder in multiple sclerosis has always been a matter of great interest. Ever since Charcot's time it has been known that the axis cylinders remained intact, although the myelin sheath disappeared. This could be seen in the fresh focus of the disease. In the older ones they could no longer be seen. As it was gen-

erally the old cases of the disease which came to autopsy, the difficulty of demonstrating this is apparent. In the old foci of disease it is always difficult to distinguish between neuroglia and connective tissue fibres and true nervous structure. Before this question could be finally settled an elective staining method must be used. Such a method has been devised by Fajerstain by means of impregnation with silver salt. The author studied with this method the spinal cords in longitudinal sections of four cases of multiple sclerosis, the most recent of which was one and a half years' duration and the oldest ten years. In all of them there was no evidence of secondary degeneration. Intact axis cylinders were demonstrated in these sections.

The Ætiology of Tabes, with Special Reference to the Relation Between Trauma and Tabes.—SCHITTENHELM (*Deutsche Zeit. fuer Nervenheilkunde*, Band 24, Nos. 5, 6, 1903).—Statistics on the syphilis tabes question are always of interest, especially so when the statistical material is large. This paper is based upon a ten years' clinical material, which amounted to 128 cases, in which the diagnosis was absolutely certain. There were 102 males and 26 females in this number. Of the 102 men, 54 had undoubted syphilis, 15 probable, and 33 had not. Of the 16 women, 10 had, 4 probable, and 12 no syphilis. This amounts to a percentage of 67 in the former and 54 in the latter. The author reviews the cases in the literature of the so-called traumatic tabes, at the same time considering his own material from this point of view. He concludes as follows: A traumatic tabes in the strict sense of the term does not exist. Cases in which a trauma is followed by symptoms of tabes can only be brought in relation with it as an ætiological factor by the supposition that the trauma plays the role of an exciting cause. The trauma acts as a predisposing moment, or in an individual who is already predisposed to tabes the trauma brings to light the already latent symptoms, or, if they already exist, renders them more apparent and intensifies them.

Opocerebrin Treatment of Epilepsy.—PROBST (*Psych. Neurol. Woch.*, No. 29, 1903).—Since the appearance of Poehl's spermin preparations for the treatment of various functional nervous diseases, there have been numerous examples of the so-called organo-therapeutic products devised. The newest of these are made from the tissue juices instead of from the organs themselves. In this way the leucomaines, which are supposed to be held in solution, are made use of. Opocerebrin is one of the latest of these products. It is made from the gray substance of sheep's brain. Probst tried this preparation in nine cases of epilepsy in daily doses of 0.2 grams, together with 3 grams of sodium bromide. None of the cases showed any improvement whatever. The author concludes that the effect of these tablets is absolutely negative.

Stomach Phenomena in Migraine and Epilepsy.—MANGELSDORF (*Berl. Klin. Woch.*, No. 44, 1903).—In examining a patient with migraine for stomach symptoms, the author found marked evidences of enlargement of the stomach. This was especially noticeable after an attack. Since then all cases of migraine were examined with the purpose of testing the correctness of the original observation. Out of four hundred and sixty nine cases of migraine the size of the stomach was determined in four hundred and nine. In only one was the stomach found to be normal. In a number of cases of epilepsy a similar condition was found. The close connection between the two conditions points the same general cause for the prevalence of gastric atony in the two diseases.

A Method for the Relief of Pain in Tumors of the Brain.—BROWNING (*Journal Nerv. and Ment. Disease*, November, 1903).—The chief therapeutic problem in inoperable cases of brain tumor is the relief of pain. A certain number respond

to thyroid or to the iodides. The x-rays have been found in a few cases to benumb the pain temporarily. Browning recommends the administration of such depressants as aconitia, veratrum or gelsemium in doses sufficient to control and soften the pulse. The remedy can be continued as required, though the condition of the circulation should be frequently observed and the amount of the drug regulated accordingly. The dosage in any particular case is kept where it does not dangerously reduce the pulse on the one hand, and yet control the pain on the other.

The Dietetic Treatment of Epilepsy.—MEYER (*Berl. Klin. Woch.*, November 16, 1903).—This is an account of a series of cases in which the dietetic treatment was carried out with great care. Four cases formed the material upon which the experiment was tried. No medication whatever was given for a period of four weeks; during this time observations could be made for comparison with the period of actual treatment. The cases averaged twenty years, and were all of a severe type of the disease. Balint's latest diet was used, including the especially prepared bread to which he has given the name bromopan. This is a saltless bread, baked with 1 gram sodium bromide to each 100 grams of bread. The patients were under observation from two to five months. The following diet was planned for each patient:

6:00 A. M.— $\frac{1}{8}$ to $\frac{1}{4}$ L.	cocoa,	coffee, $\frac{1}{4}$	bromopan, egg.
9:30 A. M.— $\frac{1}{2}$	"	milk, $\frac{3}{4}$	" egg, fruit.
12:30 P. M.— $\frac{1}{2}$	"	milk, 1	" 2 eggs, fruit.
4:00 P. M.— $\frac{1}{8}$ to $\frac{1}{4}$	"	cocoa,	
		coffee, $\frac{1}{4}$	"
6:00 P. M.— $\frac{1}{2}$	"	milk, $\frac{1}{4}$	" fruit.

The results were as follows: In all cases the attacks decreased in number and in severity. In two cases the psychical improvement was very marked. All the cases bore the treatment well, and gained in weight during the period of treatment. A daily bromide dose of 3 grams was sufficient in each case. The author believes that this treatment, while it does not offer the possibility of a cure, yet is far more effective than any method that has yet been devised.

GENITO-URINARY SURGERY

IN CHARGE OF

H. MCC. JOHNSON, M. D.

Cancer of the Prostate.—GREENE (*New York Med. Jour.*, October 24, 1903).—The author has endeavored to collect all recent articles on the above title in order to classify the early symptoms, and thus aid a correct diagnosis in view of taking the disease in time, so that the surgeon may entirely check the growth, or, at least, prolong the life of the patient. It is only in late years the distinction has been made between cancer of the prostate and that of what was then called sarcoma of the prostate. In the majority of cases the so-called hypertrophied prostate of the aged is a chronic inflammation. Naturally, then, we can expect a cancer to follow, as it often does in other parts of the body, if any inflammation is left to become chronic. According to the examinations of Alberan and Halle, as high as fourteen out of one hundred of so-called hypertrophies of the prostate were found to be cancer. It is doubtful if not more of the hyper-

trophied prostates were not cancerous. Greene and Brooks report three cases of cancer in fifty-eight examinations of hypertrophy.

The author states that the very important subject of early infection of the lymphatic glands has been discussed thoroughly by Pasteau. He gives eighty-five per cent. as the proportion of affected lymphatic glands, thus making it hopeless to operate unless before glandular metastasis sets in. This is where the difficulty lies: how early does cancer of the prostate occur? An average, according to histories, one would say over fifty years of age, although there are exceptions. One was reported by Carlin as young as thirty-eight. In a great many cases the patient has trouble with the prostate several years before the cancer develops. Cachexia hardly need be mentioned as having any especial diagnostic value, but if it appears suddenly in an old prostatic, it may lead to a suspicion that a malignant growth exists. On the other hand, pain seems to be quite an accompaniment of cancer, and as it may occur before metastasis into the neighboring lymphatics has set in, pain in an old prostatic without other cause to account for it, should lead to operative means immediately, if no strong reasons are against it.

Bloody urine, when in connection with these former symptoms, is a common occurrence in cancer. Careful use of the cystoscope is of great aid.

The amount of residual urine helps very little in diagnosing, due to the fact that cancer of this organ can be yet too small to obstruct the urinary flow. Most of these cases, however, have previously had gonorrhea.

Correct diagnosis as to cancer or not, by rectal or urethral examination, is very uncertain. Guipin considers the feeling of a cyst, the contents of which cannot be made to disappear by massage of the gland, to be one sign of cancerous growth. A sudden increase in the size of the prostate in an old prostatic is unfavorable. Cancer more usually locates in the lateral lobes of a gland than in the so-called third lobe.

The author cannot help but agree with Pasteau on account of the extensive metastasis which takes place. These cases are almost always fatal. But if they can be taken in the earliest stage, surgical intervention may save the patient, or at least prolong life quite a period.

Conservative Perineal Prostatectomy.—YOUNG (*Jour. A. M. A.*, October 24, 1903).—Young relates his experience with prostatectomy and Bottini's operation, but has recently turned his attention to perineal prostatectomy. The fact that many of the cases requiring prostatectomy are vigorous men in the fifties, with sexual powers well preserved, renders it important to do nothing to injure their manly vigor, and so Young has devised an operation which leaves the ejaculatory ducts intact. He makes an inverted V-shaped external incision, which he carries through the skin down to the muscles without severing them, except in the immediate median line. Here he cuts the central tendon and the recto-urethralis muscle. This allows the rectum to be retracted backwards, and exposes the apex of the prostate. The membranous urethra is now opened, and the author's retractor introduced into the bladder. With this he is enabled to bring the prostatic capsule well within view and touch. An incision is now made into the capsule on each side of the median line, leaving enough interspace to comprise the urethra and ejaculatory ducts. Through these incisions the lateral lobes and even the median lobe are by blunt dissection enucleated without tearing the bladder or urethral wall. The bladder is drained through the incision in the membranous urethra, the cavities in the prostatic capsule stuffed with gauze and the external perineal wound partially stitched together.

Fifteen cases operated upon have all recovered, but are of too recent date for report as to permanent results. Young says that the instrument which he here exhibits and calls his "prostatic tractor" has transformed for him the operation from a hap-hazard to an accurate one. The article is well illustrated.

Prostatectomy and Galvanocaustic Prostatotomy (Bottini's Operation): Their Present Status in the Radical Treatment of the Hypertrophied Prostate Gland.—MEYER (*Medical Record*, October 24, 1903).—The relative merits of prostatectomy and the Bottini operation are discussed. The author reports for the Bottini operation in his hands a death-rate of seven out of fifty-nine cases. He seems to have run up against the usual complications of this operation quite frequently. In five of the fifty-two cases that are tabulated as recovering from the operation, the membranous urethra was accidentally injured. In one patient the rectum was injured, and a recto-urethral fistula established. Epididymitis and suppuration of the testicle were among the complications. Much other data in regard to the patients are given—of not a very encouraging nature. Interference with the power of intercourse was noted in several cases. The author concludes by saying:

1. The operations making a direct attack upon the enlarged prostate gland are preferable to those aiming to exert an indirect influence.
2. We have two useful procedures for the direct treatment of the enlarged prostate gland—that is, prostatectomy and galvanocaustic prostatotomy (Bottini's operation.)
3. In selecting the method indicated in the given case we must individualize and be guided by anatomic, pathologic and social conditions.
4. Prostatectomy is the most radical and most surgical procedure; it should be the operation of choice whenever promising success.
5. Perineal prostatectomy offers advantages over the suprapubic method, since it enables the operator to do the operation under the guidance of his eyes.
6. Debilitated patients, who seem unfit subjects for the more radical operation, should not be at once relegated to catheter life, nor should prostatectomy be performed in order "to let them down easy;" they should be advised to have Bottini's operation done if possible.
7. Surgeons should familiarize themselves with both methods, in order to be in a position to do justice to their patients.
8. It is the duty of those refusing to do Bottini's operation under any circumstances to nevertheless advise the latter in cases in which the patient asks for more radical relief, and the operation with the knife seems contraindicated.
9. Further carefully compiled statistics as to the results of both operative procedures—preferably in the hands of one man—are desirable, in that they will increase our knowledge with reference to the selection of the proper method in the individual case.

Treatment of Gonococcal Urethritis by the Method of Janet.—GUIARD (*Ann. des Mal. des Org. Genito-Urin.*, October 15, 1903).—In this article an attempt is made to answer certain opinions expressed recently in the *Annales* by Saxahausky which the author considers erroneous. Douches of permanganate of potash in the treatment of acute gonorrhea have truly a marvelous efficacy, provided they are used upon the whole canal and not simply upon the anterior urethra. The difficulty or impossibility of their execution, because of the resistance of the membranous sphincter, is due to a defective technique; and a good syringe offers great advantage over an atmospheric pressure apparatus. Previous cocaineization of the urethral mucous membrane, by diminishing or suppressing the reflex contractions of the sphincter, facilitates the manœuvre very much. It is important that the douches should be begun during the three first days. It is not necessary to use more than 500 grammes at a sitting, but it is well to have the temperature about 40° C. It is indispensable to practice two douches daily for the first four days, one usually sufficing for the next four. However, if the gonococci reappear, it is necessary to immediately resume the two daily douches.

LARYNGOLOGY AND OTOTOLOGY.

IN CHARGE OF

WILLIAM E. SAUER, M. D.

Concerning the Window Resection of the Deviated Nasal Septum.—MENZEL (*Archiv fuer Laryngologie*, Band 15, Heft 1).—The author calls attention to the disadvantage of the original method of Krieg in the reduction of septal deformities. He points out that in order to establish a free nasal passage so much of the mucous membrane is removed that not only does the patient complain of a feeling of dryness in the nose, but is greatly annoyed by the formation of crusts at this point. Another disadvantage is the length of time required for the wound to heal, which is from four to eight weeks.

In order to overcome these disadvantages the writer, instead of removing the mucous membrane with the cartilage, removes only the cartilage and as much of the bone as necessary between the two layers of mucous membrane, leaving the latter intact as far as possible. To accomplish this he divides the mucous membrane on the convex side by a single incision, and then dissects it from the cartilage. The cartilage and bone is then removed with forceps and scissors. The mucous membrane is then brought back in place and kept there by packing both nasal passages with gauze. These gauze tampons are removed in forty-eight hours, when the convex side is again packed for another forty-eight hours, after which further packing becomes unnecessary. Complete healing takes place in from eight to fourteen days. His results are all very satisfactory. However, he calls attention to some saddle-noses among his first cases, which were due to removing too much of the cartilage just beneath the bridge of the nose.

Primary Erysipelas of the Larynx.—KOUTCHERSKI (*Prakticheski Vrach*, June 21, 1903; rev. *N. Y. Med. Jour.* and *Phila. Med. Jour.*, October 31, 1903) reports the case of a woman, aged forty-eight years, in whom he discovered erysipelas in the larynx. The disease began with fever and prostration, pain on swallowing and difficulty in breathing. On the following day the larynx showed pain on pressure externally, and a very marked redness and swelling of the right aryteno-epiglottic fold, together with paresis of the right vocal cord. The pain increased rapidly, swallowing became impossible, and speech difficult. On the following day there was a marked swelling and redness of the entire epiglottis. The temperature was moderate and the pulse slightly accelerated. During the next few days the larynx gradually assumed its normal appearance, but the patient became delirious, with hallucinations of sight and hearing, which gradually disappeared. During one of the examinations, at the height of the disease, the larynx showed light-grayish false membrane, which quickly disappeared, leaving a superficial ulcer. The rapidity and intensity of the local process and the character of the general symptoms led the author to the diagnosis of primary erysipelas of the larynx.

The Treatment of Diseased Faucial Tonsils in the Adult.—DAVIS (*N. Y. Med. Jour.* and *Phila. Med. Jour.*, October 31, 1903).—The writer wishes to direct attention to a form of tonsillar disease which is frequently overlooked, viz., the small or innocent-looking, or so-called submerged, tonsils. There is usually a history of repeated attacks of amygdalitis or circumtonsillar abscesses. Other symptoms are hawking, cough, pain in deglutition (at times), impaired hearing,

change in the voice, otitis, neuralgia, etc. The throat is easily affected by climatic changes. Examination reveals usually a small tonsil of normal color, surface smooth, with scattered here and there a few small nodules with an indurated base. The crypts are usually deep and filled with cheesy masses; the tonsil will be adherent to the pillars, and in many cases the adhesions are so extensive that the pillars and tonsils form one agglutinated mass. These adhesions alone are sufficient to give to the patient a great amount of suffering.

As to the method of dealing with these conditions, the author states that the same rule applies here as in general surgery, viz.: that all diseased tissue must be removed and no time wasted with sprays and paints. For the removal of these tissues, Davis prefers Freeman's tonsil punch. With this instrument the entire tonsil can be removed in one sitting with very little pain to the patient and no danger from hemorrhage.

Mastoid Disease and Extradural Abscess.—OPPENHEIMER (*Medical News*, November 7, 1903) believes that a distinction should be made between a true epidural abscess—that is, a collection of pus localized and confined between the inner osseous wall and the brain membranes—and the so-called extradural suppurations, which are more or less frequently found during an extensive mastoid operation, when the dura is in part exposed and forms a portion of the inner wall of the purulent cavity in the mastoid. Epidural abscess is the most frequent complication of mastoiditis, and may be the cause of the sinus infection, or may be responsible for the development of brain abscess. The two most common sites for the development of the pus collections in the order of their frequency are, first, in the posterior fossa near the vertical portion of the groove for the lateral sinus, and, secondly, in the middle fossa on the superior surface of the osseous tissue forming the roof of the antral cavity. The dangers are increased when the pus collection is in close relationship to the sinus, on account of the tendency to secondary inflammation and thrombosis. The symptoms present in the early stage of extradural abscess possess no special characteristics, although one may suspect the existence of this condition when, in the presence of mastoid symptoms, the aural discharge suddenly becomes less or ceases entirely and the patient shows signs of meningeal irritation. The two most conspicuous signs in a number of cases are, severe and continuous headaches localized over the affected area, and moderate elevation of temperature, seldom reaching over 102 degrees, undergoing slight fluctuations, but seldom reaching the normal. Even under most favorable conditions the diagnosis of extradural abscess is both indefinite and obscure. In many cases evidences of extradural abscesses are only disclosed when during a mastoid operation a fistula is found leading into the cranial cavity. The prognosis is very favorable if the abscess be evacuated by operative procedures. No other treatment than the surgical release of the purulent collection should be considered.

The Arch of the Palate.—SWAIN (*Laryngoscope*, October, 1903).—After having studied and made numerous measurements of the skulls and palates of different races in order to determine the causative factors in the production of the high arched palate, the author believes to have demonstrated:

First, that it is possible by deforming processes which artificially alter the shape of the skull, to produce a change in form and shape of the hard palate.

Second, that under these above-mentioned conditions the septum seems to conform itself to the altered development of the rest of the face, rather contrary to our previous ideas regarding the habits of this structure.

Third, that if from arrested or retarded development of the superior maxilla the palate fails to descend to its proper level, a bent septum is as liable to

be produced as when the palate is arched too greatly by an unnatural narrowing process. Hence a palate of perfectly normal height as compared to breadth may produce a bend in the septum.

Fourth, that in considering the various causes which produce the abnormalities of the palate, we must lay more stress upon the lack of proper aeration of the maxillary sinuses retarding their development and hence that of the whole superior maxilla.

Fifth, the conservation and general care of the deciduous teeth help to produce a normal horizontal curve in the hard palate and lessen the tendency to narrowing.

OPHTHALMOLOGY.

IN CHARGE OF

JOHN GREEN, JR., M. D.

Tuberculosis of the Conjunctiva.—E. JACKSON (*Ophthalmic Record*, September, 1903).—Jackson's patient was a little girl of ten years, whose trouble began with swelling of the left cheek and left side of the neck, six weeks prior to coming under observation. There was fever and vomiting. Two weeks later the left lids became swollen.

Examination showed marked swelling of the lower and slight swelling of the upper lid of the left eye. A tumefaction just behind the angle of the corresponding side was composed of enlarged lymphatic glands rounded out by edema. The patient was anemic and constantly losing weight. The mother had scrofulous glands in childhood. The conjunctiva of the upper lid was smooth, hyperemic, slightly thickened, and studded with numerous points like small trachoma granules. Large trachoma-like granular masses were observed near the margin of the lower lid, which was greatly thickened. A whitish, apparently fatty or necrosed tissue occupied that portion of the lid adjoining the retrotarsal fold. The center of each granule was gray and translucent with minute vessels entering it from a surrounding vascular zone. Between the granules and on the surface of the white tissue appeared a slight gray sticky discharge. Tubercle bacilli were repeatedly found in the discharge, but always in small numbers.

Jackson considers the swelling of the neck secondary to the conjunctival lesion which at first escaped detection.

Epiphora as an Initial Symptom in Basedow's Disease.—E. BERGER (*Archives of Ophthalm.*, September, 1903).—According to Sattler, epiphora occurring in this disease is due (1) to excessive secretion of tears resulting from the exposure to the air of an abnormally large portion of the anterior segment of the exophthalmic globe, and (2) to infrequent winking and incomplete closure of the lids, resulting in imperfect drainage. In Knies' opinion the condition is caused by irritation of the sympathetic.

In the four cases reported by Berger, epiphora appeared as the initial symptom, preceding by several years the usual signs of the disease. In each case treatment based on the assumption of an obstruction to the drainage apparatus (probing, astringent injections, etc.), proved wholly unsuccessful.

Berger regards the epiphora as a "secretory neurosis of the lachrymal glands. The weeping, caused through the fifth nerve, is to be explained as being due to a reflex condition of sensory excitation to the sympathetic vasomotor fibres in the glands."

Idiopathic Myositis Involving the Extraocular Muscles.—J. E. GLEASON (*Ophthalmic Record*, October, 1903).—In the past fifteen years thirty-five cases of primary or idiopathic myositis have been reported, but hitherto no case of direct and exclusive involvement of the extraocular muscles. The patient, fifty-nine years of age, suffered from occasional ill-defined rheumatic attacks. Ocular trouble began four months prior to coming under observation, with swelling of the lids and conjunctivitis. Later, severe chemosis and pain. Examination showed right exophthalmus, marked chemosis, the epithelium of the cornea "horny and desquamated" (from exposure to the air) and iritis. Movements were much restricted and painful and there was binocular diplopia. Treatment (cold applications and strychnia) proving ineffectual, exploratory incision revealed an enlarged superior rectus. Finally enucleation was performed on account of severe pain and impending panophthalmitis. The superior rectus was found "enormously enlarged, immovable, hard and board-like to the touch." Microscopically, an acute interstitial myositis with parenchymatous changes (edema, hemorrhages and simple and coagulation necrosis of the muscle fibres).

Two months later the left eye passed through an identical attack and, developing purulent keratitis, was likewise removed. All the extraocular muscles were involved in the inflammation. In neither eye was orbital cellulitis present, nor were any bacteria found.

The writer believes that rheumatism was the etiological factor, and gives the following reasons for assuming that the myositis was primary: (1) In the right eye the superior rectus was the only muscle involved (if the inflammation had extended from a tenonitis, all the muscles would have been equally involved); (2) myositis has never been observed secondary to a tenonitis; (3) the involved muscles retained their shape and were distinct from their surroundings; (4) the globes remained free from involvement until a secondary process began through exposure of the cornea.

The author adds an historical account of primary myositis since its recognition by Friorep and Virchow, fifty years ago.

The Danger that May Lurk in Blind Eyes.—WESCOTT and PUSEY (*Am. Med.*, August 29, 1903).—The authors discuss the danger that may accompany some single blind eyes, excluding eyes blinded by optic atrophy accompanying cerebral or spinal disease, by retinitis pigmentosa, by primary glaucoma or by idiopathic detachment of the retina. Calcification of the contents of the globe may induce a sympathetic inflammation without premonitory signs of sympathetic irritation, and eyes in which this condition probably obtains should be removed. An eye long blind from injury may give rise to sympathetic inflammation in spite of the fact that, clinically, it appears to be absolutely quiet. On microscopic examination such eyes may exhibit signs of chronic inflammation of the anterior segment. A shrunken deformed globe with moderate bulbar injection, blind as the result of an explosion, was enucleated and found to contain a splinter of iron. Among other blind eyes demanding prompt removal are beginning sarcomata of the choroid and gliomata of the retina. The committee of the Ophthalmological Society of the United Kingdom did not find "a record of any case of sympathetic ophthalmitis following evisceration without the insertion of an artificial globe," whereas in five cases, sympathetic ophthalmitis developed after a Mules operation (introduction of an artificial globe into the emptied sclerotic). Histological examinations of recently eviscerated globes have shown the presence of spots of retained uveal pigment which may harbor micro-organisms. The situation is tersely summed up by the concluding sentence of the paper: "If thine eye offend thee, pluck it out."

A Case of Vernal Conjunctivitis.—F. ALLPORT (*Ophthalmic Record*, October, 1903).—In a case of palpebral vernal conjunctivitis recurring each summer for

seven years, Allport amputated the warty, flattened growths and exposed the everted conjunctiva to the x-ray. Eighty exposures of from three to ten minutes' duration were given from June to September, at which time the growths were replaced by smooth and harmless scar tissue. During the treatment there was no photophobia, itching or irritability and the drooping lids disappeared.

Electro-Cautery Incision for Ectropion and Entropion.—F. B. TIFFANY (*Kansas City Medical Index-Lancet*, November, 1903).—In ectropion an incision with the blade red-hot is made parallel to and two to three mm. from the edge of the lid, going through the mucous membrane down to the tarsus. Severe cases require two or even three incisions. In entropion the incision is made in the skin from the punctum to the outer canthus, three mm. from the lid margin. The cut should not be too deep nor too near the edge, lest the base of the ciliary follicles be injured. The cicatrix turns the lid to the normal position and in a short time becomes practically invisible. The operation is suitable for the majority of cases.

MISCELLANEOUS NOTES.

Work on the model hospital building in which the medical staff will care for the sick and injured during the Exposition was begun October 7th by E. L. Wagner & Sons, who had taken the contract at \$16,465. The building is practically finished and will be dedicated at an early date. It is to be a perfectly equipped modern emergency hospital, part of the Model City exhibit, a street of which will run parallel with the east facade of the manufactures building. The hospital will be 108x109 feet and will have besides offices and operating rooms for the medical staff, dormitories for the matron and nurses.

District nursing has been established in St. Louis. This is a system for supplying expert nurses to that class of sick who are averse to going to a charity hospital, yet are unable to pay for the services of a trained nurse. The plan is to have a nurse go to the house and spend a half hour or an hour once or twice daily—bathe the patient, take the temperature, arrange the room and bed, administer douches, enemata, etc., and instruct the patient and friends how to carry out the various measures ordered by the physician. Where the patient is able to pay a small fee is charged—25 to 50 cents for each visit. If the patient is unable to pay no charge is made. The Advisory Board consists of Dr. H. S. Crossen, chairman, Drs. L. H. Laidley and E. W. Saunders.

Dr. William Warren Potter, of Buffalo, N. Y., secretary of the American Association of Obstetricians and Gynecologists, reports through Dr. W. B. Dorsett, of St. Louis, that the association has accepted the invitation of President Francis of the Exposition to meet in this city next year. The meeting will be held September 13th, 14th and 15th. The St. Louis members of the association are Drs. B. M. Hypes, John Young Brown, C. R. Dudley, L. H. Laidley, Wm. A. McCandless and W. B. Dorsett.

One of the prizes of the Nobel foundation will be awarded to Dr. Niels R. Finsen, of Copenhagen, whose method of treatment with concentrated rays of chemical light has proved so successful in lupus and other diseases heretofore regarded as incurable. This is a proper recognition of the work of Dr. Finsen.

Bearing on this method of treating such conditions it is worthy of note that the Finsen Light Institute of America has been established in Chicago and is equipped with apparatus imported direct from the Finsen Institute at Copenhagen. It is in charge of competent men who have been trained in the work under the supervision of Dr. Finsen.

The Avarenga prize of the College of Physicians of Philadelphia for 1903 was awarded to Dr. William S. Carter, of Galveston, Texas, for his essay entitled: "The Relation of the Parathyroids to the Thyroid Glands."

Dr. E. W. Cannady was awarded the prize offered by the Medical Society of the City Hospital Alumni, of St. Louis, for the best essay submitted by Junior Internes during 1903. The subject of Dr. Cannady's paper was "Typhoid Fever vs. General Miliary Tuberculosis."

Dr. Clark Bell, of New York, chairman of the Committee of Organization for the International Congress on Tuberculosis, to be held in St. Louis on October 3, 4 and 5, 1904, writes President Francis that the governments of Ecuador and Mexico have accepted the invitation extended by the United States Government to participate in the congress. The invitations to foreign countries were issued only a short time ago. Chairman Bell also reports that delegates to the convention have already been appointed by the governors of Georgia, Missouri and New Jersey and the State Board of Health of Missouri. He states that every "indication now points to a great meeting at the session of the American Congress on Tuberculosis at the World's Fair at St. Louis in October, 1904."

BOOK REVIEWS.

A COMPEND OF HUMAN ANATOMY. By SAM'L O. L. POTTER, M. A., M. D., etc. Seventh edition. Revised and enlarged. P. Blakiston's Son & Co., Philadelphia.

This edition of the well-known Quiz-Compend is enlarged by eighty-two pages and contains many more illustrations and should be more popular than ever. As long as medical students have their days occupied by didactic instruction, compends and abbreviated and condensed syllabi remain the only means of preparing their "lectures," and as we have thus created a demand for these "short-cuts" we must greet with pleasure one so excellent within its short limitations as Potter's Anatomy.

A TEXT-BOOK OF CLINICAL ANATOMY FOR STUDENTS AND PRACTITIONERS. By DAN'L N. EISENDRATH, A. B., M. D. W. B. Saunders & Co., Philadelphia, New York. 1903.

This new work is intended to give a comprehensive but concise survey of anatomical knowledge as applied to every branch of clinical work, and the author has produced a very satisfactory volume, making available such points as we often want and frequently cannot obtain except from some special treatise. It will be a valuable addition to the general practitioner's library and will aid the student materially. The volume is handsomely bound and contains numerous high-class illustrations.

INTERNATIONAL CLINICS. Vol. IV. Twelfth series. 1903. J. B. Lippincott Company.

The policy of the International Clinics is well known. The contributions to this number are quite up to the usual standard. Among them may be mentioned an article on the treatment of chronic gastric catarrh by Stern, the treatment of aneurisms by gelatin in hypodermic injections by Lancereaux, a monograph on the blood in health and in disease, etc.

It is needless to state that the contributions to the International Clinics contain the best information obtainable on the subjects treated. One needs but observe the list of contributors to feel satisfied on this point.

THE PRACTICAL MEDICINE SERIES OF YEAR-BOOKS. Volume VI. General Medicine. Edited by FRANK BILLINGS, M. S., M. D. The Year Book Publishers, Chicago.

This volume is one of a series of ten issued at monthly intervals, and is intended to give to the physician, in a useful form, the most approved knowledge of the subjects touched upon. The volume in hand deals with typhoid fever, malaria and the diseases of the gastro-intestinal tract.

A MANUAL OF SURGICAL TREATMENT. By W. WATSON CHEYNE, C. B., M. B., F. R. C. S., and F. F. BURGHARD, M. D., M. S., F. R. C. S. In seven volumes. Vol. vii. Lea Brothers & Co., Philadelphia and New York. 1903.

This handsome volume of 559 pages completes the most extensive work in our language on surgical therapeutics. The first volume of the series was in some respects disappointing, and justified the criticism of being behind the

times; however, too much cannot be said in praise of the other numbers which have gone to make up the series. This seventh volume is a worthy successor to the preceding five, and the reviews of them which have appeared in these columns make it unnecessary to write more of the book before us than to state its contents.

Here are considered the treatment of the surgical affections of the rectum, liver, pancreas, spleen, genito-urinary organs, breast and thorax. The illustrations are most aptly chosen for the purpose at hand; in addition to the many which are original, a large number have been borrowed, among which are many worthy of note which have been taken from the French work on the rectum by Quenu and Hartmann.

The especial value of such a work over the ordinary text-book lies in the fact that a comparison of methods can be made, since there is enough space at the author's command to enable him to give all that the literature affords on a given subject, instead of having to confine himself to the one operative method which he individually may consider best in a given pathologic condition.

The author's excuse for the tardy appearance of the book is that it was greatly extended beyond the limit originally intended; surely every reader will be minded to pardon this single fault, in consideration of the value received.

THE SURGERY OF THE HEAD. By BAYARD HOLMES, B. S., M. D. D. Appleton & Company, New York. 1903.

This work is evidently one of a number on "surgical emergencies" and is intended for the use of the general practitioner. It is small, concise, contains 569 pages and is illustrated with 90 cuts. The consideration of the well-established specialties has wisely been entirely omitted, and there is no effort to go deeply into any but the routine cases. In other words, the idea is to give the general practitioner as much information as possible upon exactly those subjects that he is most likely to be called upon to treat. The author is so generous as to give what might hardly be expected in such a work, viz., a chapter upon the parotid gland, one which is, by the way, very readable, though necessarily so brief as not to be of much avail in more than helping the physician to establish the indications for treatment.

DISEASES OF THE NOSE AND THROAT. By CHARLES HUNTOON KNIGHT, A. M., M. D., Professor of Laryngology, Cornell University Medical College; Fellow New York Academy of Medicine, of the American Laryngological Association, of the American Academy of Medicine, of the American Therapeutic Society, etc. Price, \$3.00. Philadelphia: P. Blakiston's Son & Co. 1903.

The author states in his preface that the contents of this volume formed the basis of a course of lectures at the Cornell University Medical College and have been arranged chiefly for the convenience of students.

The book consists of 416 pages of text, with 147 illustrations, the latter being chiefly reproductions from German works. Nearly one-half of the work is devoted to the nose, the remainder being about equally divided between the pharynx and larynx. Anatomy and physiology are considered separately under each division, thus dividing the work into three distinct parts. Only the very essentials of anatomy and physiology are given. He points out that there are still many unsettled questions as to the innervation of the larynx and action of the vocal cords. He also calls attention to the many theories of intranasal pathology. Under the head of nasal neuroses the author makes the statement that it must be admitted that many of the relationships that are said to exist, exist only in the imagination of the observer. Only those therapeutic measures which have

best served the author during his long clinical experience are dwelt upon. This work, while containing nothing new, is of value as it clearly gives the author's views on these special branches.

NOSE AND THROAT WORK FOR THE GENERAL PRACTITIONER. By GEORGE L. RICHARDS, M. D., Fellow of the American Laryngological, Rhinological and Otological Society; Fellow American Otological Society; Associate Editor *Annals of Otology, Laryngology and Rhinology*; Otologist and Laryngologist, Fall River Union Hospital, Fall River, Massachusetts. Price, \$2.00. Published by the International Journal of Surgery Company, New York.

In this neat little volume of 320 pages the author has endeavored to select from the large field of laryngology and rhinology such matter as may be of practical value to the general practitioner. The chapters are concisely written and only the necessary data for a clear understanding of the subject are given. Special stress is laid on the therapeutic measures. Some of the measures here advocated, especially the surgical procedures, cannot be carried out by the general practitioner, not only because of the lack of special training, but the lack of equipment, as the number of instruments required would hardly be found among the armamentarium of the man who does general work. However, the work contains much valuable advice.

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